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Family Medicine

NARRATIVE ESSAY

Joy Amongst Sorrow

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I paused at the entrance to her hospital room. This was routine for me, a habit I picked up from my family medicine preceptor in medical school. A moment to refocus, to clear my mind, to be intentionally present.

Laying disturbingly still in her hospital bed was a woman in her mid-40s. Days prior, Mary had suffered a large brain stem stroke. This tragic event caused her to lose all movement in her arms and legs. She also had lost the ability to speak.

The momentary pause outside of Mary's room served a different purpose than usual. It allowed me a few moments to gather myself, to guard my emotions from the heartbreaking case that lay ahead.

Medically, Mary's was not a complex case. Our primary role as the medicine team was to stabilize her enough for transfer to a hospice care facility where she could comfortably spend her final days. Emotionally, however, her case was devastating. By now, we were aware that she had young children, was in the middle of a successful career, and was often alone in her hospital room because her family couldn't bear to see her in this condition.

Mary was often sleeping when I entered the room. Or was she actually awake and just unable to communicate with me? Afraid of waking her and bringing her back to her reality, I often hurried through a cursory exam. A glimpse at her vitals on the monitor. A quick, cautious listen to her heart and lungs, careful not to disturb her. Checking to see whether she was in a comfortable position in the bed.

Stepping out of her room, I paused to take another minute to collect myself. The nurses and I spoke in hushed tones in the hallway, discussing the plan of the day and reflecting on how unfair medicine can be.

After seeing Mary, I took the long way to the rounding room. Bypassing the elevator for the stairs allowed me a few more moments to collect my thoughts and reset my mood. It was early in July, meaning our inpatient medicine team was staffed by a team of new resident physicians. Early weeks on inpatient medicine can be daunting for new residents, so I wanted to come to rounds with my best self—prepared, insightful, chipper, helpful.

My final day on the inpatient team, I saved rounding on Mary for last. As I entered the room, I found one of our new residents, 2 weeks into her intern year, sitting on a stool next to Mary's bed, holding her hand. To my surprise, Mary was awake. Dr Valdez and the patient were having a conversation, but not in the traditional sense because Mary could communicate only by blinking.

I paused and watched the encounter from the doorway

"You have a beautiful view of the mountains from your room. What is your favorite time of day to watch outside?"

"The morning sunrise?" Pause.

"The evening sunset?" Pause.

"Seeing the valley light up at night?"

This last question was followed by a few affirmative blinks from Mary. Dr Valdez followed this response with a smile, herself acknowledging how beautiful the sights were from the higher floors of the hospital at night.

The conversation carried on in such a fashion through many topics, such as Mary's favorite music, activities she enjoyed doing with her children, and places she enjoyed visiting in her hometown.

Despite undoubtedly being constrained by time on a busy inpatient rotation, Dr Valdez showed no sign of urgency or impatience. She never lost focus on Mary, demonstrating that she was present in the moment. Dr Valdez clearly was doing her best to foster a human connection in these most difficult circumstances.

As I pulled up a chair to hold Mary's other hand, I felt an immense sense of admiration for this empathetic and compassionate new physician. But this emotion also was partnered with a sense of shame that I had not modeled similar behavior to the team.

I usually pride myself on my ability to connect with patients, to learn about their passions, their challenges, and the things that bring them joy. However, the tragic nature of this case led me to build emotional walls, aiming for efficient provision of medical care rather than exploring nontraditional communication methods that might have helped me foster a more therapeutic relationship.

I also had become overwhelmed by the start of the new academic year, getting caught up in the exhaustive mental lists of orientations, trainings, and double checks that come with a new class of residents.

Dr Valdez wrapped up the encounter beautifully, laying a gentle hand on Mary's shoulder and thanking her for sharing in the conversation that morning.

As we stepped out of the room together, I was speechless. We both had tears in our eyes as we debriefed in the hallway. I felt embarrassed that I had so little feedback to offer Dr Valdez in that moment. The reality was that she served as a teacher and mentor for me during that encounter. I'm continuously amazed by the bidirectional nature of medical education; we faculty physicians have as much to learn from our resident colleagues as they do from us.

This encounter allowed me to find joy in the cyclical nature of the academic calendar. Instead of focusing on the challenges that come with a new team, it is better to celebrate and embrace the new perspectives they bring, their optimism about the practice of medicine, and their commitment to this incredible career. The challenge that we should be embracing as clinical faculty is how to maintain these fresh perspectives throughout their training and into their careers.

I now hope to welcome July with excitement rather than apprehension. And I hope our new residents appreciate the positive impact they have on their patients as well as their coworkers and faculty. May we all approach our careers with the humility to learn from our learners; it is one of the greatest joys in this career.